Consumer Financial Protection Bureau

Flexible Spending Accounts (FSA) – New Enrollment Form (non Dodd-Frank)

Name *(Last)*	*(First)*	*(Middle Initial)*	SSN
Address			Date of Birth
City and State	Zip Code	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Employee E-mail Address	Location	Work Phone ( )	Home Phone ( )

Employee Contribution

Indicate the amount of your contribution only. Note that the combined total of your contributions (employee and employer, if applicable) cannot exceed $7,500 for Health Care Account (HCA) and $5,000 for Dependent Care Account (DCA).

☐ I choose to contribute to the FSA Health Care Account. I elect to deposit $_____ annually during the plan year.

☐ I choose to contribute to the FSA Dependent Care Account. I elect to deposit $_____ annually during the plan year. If I am married, I understand that my annual deposit is limited to the lesser of: $5,000 if single or married filing jointly, $2,500 if married filing separately, or my spouse's income, whichever is lower. I also understand that I – or my spouse and I—must work outside the home in order to qualify for enrollment.

Annual contributions will be divided by 26 pay periods to determine your biweekly contribution amount. If rounding is required, the contribution amount will be rounded down.

Employer Contribution (This contribution applies to employees making $110,000 or less per year)

CFPB contributes $1000 towards the plan of choice for employees making $110,000 or less per year. If this applies to you, indicate your employer contribution below. Note that the combined total of your contributions (employer & employee) cannot exceed $7,500 for HCA and $5,000 for DCA.

☐ I elect to deposit annually $_____(whole dollar amounts ONLY) of my CFPB contribution to the FSA Healthcare Account.

☐ I elect to deposit annually $ _____(whole dollar amounts ONLY) of my CFPB contribution to the FSA Dependent Care Account.

Spouse and Dependent Information *(NOTE: Please enclose information for additional dependents on a separate sheet of paper)*

Last Name	First Name	Middle Name	Social Security Number	Date of Birth	Relationship
Last Name	First Name	Middle Name	Social Security Number	Date of Birth	Relationship
Last Name	First Name	Middle Name	Social Security Number	Date of Birth	Relationship

Signature

By Signing and submitting this form, I understand that:

- I am making a binding decision;
- The total amount I have chosen to deposit in my FSA will be deducted in equal portion (not to exceed the maximum deposit amount elected) from my paychecks on a biweekly basis before taxes are taken out;
- I may not change or stop my deposits into these accounts during the plan year unless I experience a Qualifying Life Event (QLE);
- I will forfeit any balances remaining in my accounts at the end of the year

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_____ Signature

_____ Date

Return completed form: Mail: Bureau of the Public Debt/Benefits (Avery 4-K)/PO Box 1328/Parkersburg, WV 26106-1328
Fax: 304-480-8019 or Email: benefits@bpd.treas.gov

FOR OFFICE USE ONLY			
Date FSA Eligibility Verified:		Employee ID:	
Employee Contributions Biweekly Health Care: $_____		Biweekly Dependent Care: $_____	
Hire Date	Effective Date	Authorized Representative	Date

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